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Oct. - Nov.
1985



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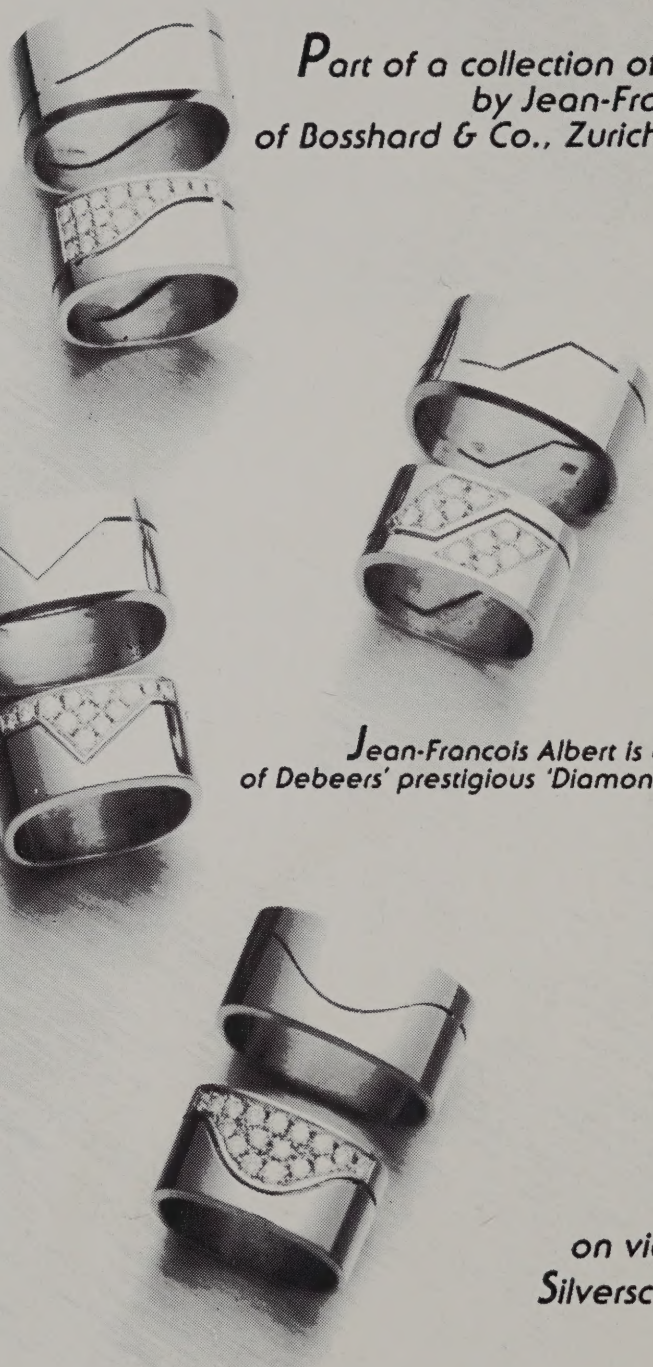

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# THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 6
OCTOBER-NOVEMBER 1985

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# THE HAMPDEN HIPPOCRAT

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OCTOBER — NOVEMBER 1985

VOLUME XXXXII NO. 6

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT is published bi monthly.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, Mass. 01109: Telephone: 736-0661.
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# HDMS President's Message

Augusto G. Asinas, M.D., President

I am glad the controversial Medicaid Access Bill did not pass the State Legislature's Health Care Committee. Had it done so it would have wrongfully forced physicians, against their will, to participate in a compensatory program, which would be tantamount to enslavement of the physicians in this state. It would have encouraged physicians to take their practice outside Massachusetts and discourage those who might wish to establish themselves here.

Congratulations are in order for the leadership of the Massachusetts Medical Society for working hard in forging an agreement for the voluntary enrollment of physicians in the program. It calls for approximately 85% of the physicians to participate in the Medicaid Program, and there is a lot of work ahead for the Medical Society to try to enlist the help of all those concerned. The State for its part has agreed to correct the inequities in the administration of the Medicaid System so as to provide the incentive for the voluntary participation by the physicians.

It behooves us all to give this agreement a chance to work. We the physicians have an obligation to the public in caring for the sick, especially those who are less fortunate than ourselves. However we should not be coerced to give services against our will for it is an affront to our dignity and honor. I am sure there are many physicians who are willing to give charitable services rather than be told that they will be paid with sums of money not commensurate with the work done. There are also patients unwilling to be treated by an unwilling physician -a situation which may give rise to future litigation!

I would like to take this opportunity to implore the membership to strongly reconsider enrolling in the Medicaid Program, especially those medical and surgical specialists needed the most. We do not want to give the legislators a pretext to threaten us in the future with what may well be an unconstitutional law of servitude. ■

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# HDMS Auxiliary President's Message

## *Why the Hampden District Medical Society Auxiliary?*

Virginia Walthall
President HDMS Auxiliary

The goals of the Auxiliary are: 1. to assist the Medical Society to improve the quality of life through health education and services; 2. to cultivate friendship and understanding among physicians' families; 3. to inform members of important legislative matters.

These goals have been guiding the Auxiliary for thirty-five years. Goals are important but they need to be backed up with commitment and conviction. The Auxiliary continues to be active because we have members who care. We care about our physician spouses and what is happening to medical practice and how it affects health care in our communities.

We support the Hampden District Medical Society in any way that we can. We are willing to organize and to make the wheels go round so that money is available for medical, paramedical and nursing scholarships.

We are a working Auxiliary. We have an active Health Education Committee that works in cooperation with the Springfield Science Museum. It has researched and produced Health Education classes that are given at the Science Museum. It has produced Health Education Loan Kits for area school children. This past year the "Smoking and Health" Kit that has been used on the local level has been reproduced on the State level and is now available to all Massachusetts school children through the State Auxiliary. Three of the Hampden District Medical Society Auxiliary kits are listed in the National Project Bank in Chicago. We feel that these Health Education projects are having a very real impact not only on the youth of our local communities but on the State and possibly even the National level.

The Auxiliary is involved with legislation as it affects the practice of medicine. The State committees carefully monitor legislation on the State level. These committees form a network that keep all of the State and County membership informed about pending legislation that can and will affect the practice of medicine.

Last but not least, the Auxiliary offers the chance to meet and to socialize. We offer programs that are designed to inform or to entertain our members.

I think that it is evident that the Auxiliary is living up to its stated goals and we can be justifiably proud of our record. But it is my sincere belief that the main reason for the existence of the Hampden District Medical Society Auxiliary is that we care about and believe in the importance of the Medical Profession, and ultimately, we care about the quality of life in our communities. ■

# AMA Auxiliary President's Message

Mary Kay McPhee
President AMA Auxiliary

"As members of the American Medical Association Auxiliary, we are today, to a degree far greater than at any other time, a powerful factor in the nation's health care equation," says Mary Kay McPhee, 1985-86 president of the AMA Auxiliary.

Mrs. William R. McPhee took office as president of the AMA Auxiliary on June 19 at their Annual Convention in Chicago, Illinois. The AMA Auxiliary, a volunteer organization of 80,000 physicians' spouses, is organized at the national, state and county levels. Primary focuses of the organization are to promote community health projects and to provide support to the medical profession.

According to Mrs. McPhee, "Auxiliary concern is tri-level and encompasses the needs of those in our communities, the needs of our members and those of our challenged profesion."

Mrs. McPhee states that the organizational goals for the coming year include promoting the cost-effective benefits of preventive health care; broadening members' knowledge and participation in health-related legislation; raising funds for quality medical education and research; and stressing the benefits of belonging to a nationwide network of volunteers.

The AMA Auxiliary has always emphasized the maintenance of good health care for all segments of the population.

The 1985-86 special focus of the Auxiliary's Shape Up for Life campaign will be on community services for older Americans. State and county auxiliaries will be involved in service programs in such areas as nutrition, physical fitness, safe use of medicines, accident prevention, and intergenerational programming.

The wife of a Kansas City, Missouri pathologist, Mrs. McPhee has held leadership positions at all levels of the association. She has served as county president, Missouri State Medical Association Auxiliary president, and at the national level as regional vice president, director and secretary. ■

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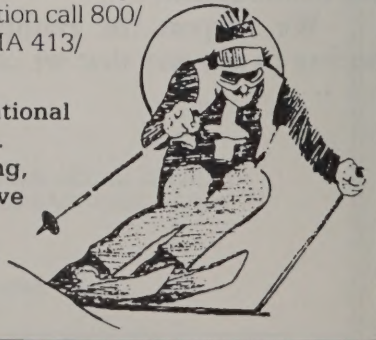

# Medicine Through The Years

by Margaret Stoler, Springfield Academy of Medicine

*In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.*

## 1736-1786

Prior to the establishment of formal medical education many physicians, most of whom were educated in Europe, offered courses in anatomy to the public at large. One of the earliest was offered in Newport, Rhode Island in 1754 by Dr. William Hunter, first cousin to the famous Dr. John Hunter, in London. Dr. Thomas Cadwalder, educated at Rheims and London presented lectures in dissection in Philadelphia. These lectures so inspired Mr. William Shippen, a wealthy merchant and community leader in Philadelphia, he sent his son, William Jr., to London to study. Upon his return in 1765, he presented a series of twenty lectures to both men and women on midwifery. In the same year, John Morgan returned from London "to see whether, after fourteen years devotion to medicine I can get my living without practicing surgery." With him he brought an apothecary and a surgeon. Morgan felt it was literally impossible for a busy practicianer to find time to thoroughly instruct an apprentice so while in London, he obtained a letter from the Proprietary, Thomas Penn, to the Trustees of the College of Philadelphia, endorsing Morgan's plan to establish a medical school that would be associated with the college. Thus was established the first medical school in the nation.

The medical school at the College of Philadelphia opened its doors in 1765 with Dr. William Shippen Jr. teaching anatomy and Dr. John Morgan, physics (medicine). By 1766, it was realized that medical students frequently had no knowledge of languages or mathematics so Rev. Dr. William Smith, provost of the college, initiated a course designed to give medical students an opportunity to "complete themselves" during their leisure hours. By 1767, those applying who did not have a college degree, would have to satisfy the trustees of their knowledge of latin, mathematics, natural and experimental philosophy. In 1768, ten men received their MB (Bachelor of Medicine) degree. Upon completing three years of practice and passing an examination or presenting a satisfactory thesis, M.D. degrees were conferred. It wasn't until 1789 that the College of Philadelphia required that the thesis be written in latin.

In 1786 Kings College (Columbia Univ.) established a medical school and was the first to offer a course in obstetrics which was taught by Dr. John V.B. Tennet. Harvard College began teaching medicine in 1782 with Dr. John Warren, brother to Dr. Joseph Warren who died at Bunker Hill, teaching anatomy and surgery. Actually, the first M.D. degree to be conferred upon an individual in the colonies was granted to an English barber surgeon by the name of Daniel Turner who wrote numerous medical books but was refused membership in the Royal College of Physicians in London because he had not attended a university. After accepting the generous donation of his books, most of which still exist, Yale College bestowed upon Turner an honorary M.D. in 1723. The medical school at Yale was not established until 1813. Some of Turner's contemporaries claimed the M.D. stood for "Multum Donavit."

With the realization of the need for formal medical education came the inevitable need for bodies to dissect. The earliest reference to dissection within the British Isles occurred in 1505 when the magistrates of Edinburgh granted the city's Guild of Surgeons and Barbers the right to dissect the body of the executed criminal once a year. By the 18th century, it was frequently left to the discretion of the Judge. Since executions were not a common occurrence at that time, the practice of grave robbing reared its ugly head and in 1767, William Shippen Jr. placed the following public

*Continued on next page*

# Medicine Through The Years

*Continued from previous page*

notice in the Pennsylvania Gazette:

> "I never have had directly or indirectly one Subject from the burying grounds belonging to any Denomination of Christians whatsoever..."

He fails to mention the public burying ground where the paupers, criminals and unclaimed bodies were put.

Those in Massachusetts were a little more devious. In the early 1770's, an anatomical society in Boston called the "Spunker Club" of which the honorable Dr. John Warren was a member, was organized under the guise of holding discussion when actually one of their main objectives was to get bodies to dissect. If the body of an executed murderer was not assigned to a physician, club members would go into action, follow the grave diggers, wait until the dead of night and snatch the body for study.

Grave robbing reached such a peak in New York City that a group of enraged citizens stormed the city hospital to retrieve all the bodies being dissected, some even extended their search to physicians' homes. The New York City Doctor's Riot of 1786 which lasted three days, forced the ruling body of the city to pass laws regulating the procurement of bodies. It was also in New York that the first regulations for the practice of medicine occurred. In 1760, any physician wishing to practice had to first be examined by "His Majesty's Councils, the judges of the superior court, the King's Attorney General and the mayor of the city." Those caught practicing without having been examined were fined "five pounds, one half thereof to the use of the person who shall sue...the other to the Church Wardens...for the use of the Poor thereof..." The Massachusetts Medical Society which was founded in 1781, was the first medical society to be granted the power to license physicians by their own examination.

The Massachusetts Medical Society was not the first society of physicians to be organized in the colony. In 1742 Dr. Sylvester Gardiner, London educated, established the Medical Society of Boston, New England, for the study of anatomy. Gardiner not only performed the most rapid operation for the removal of a stone in a six year old boy, he was also the first to open an apothecary shop. The shop was called the "Sign of the Unicorn and Mortar." It was so successful he opened two more, one in Meriden and one in Hartford. Gardiner also increased his fortune by making Medicine Boxes for merchant ships. He purchased large tracts of land in Maine including what is today Kennybunk and Gardiner.

At the outbreak of the Revolutionary War, Gen. George Washington ordered the confiscation of all the drugs in his shops. Gardiner, a stauch loyalist, proclaimed Washington an "outright thief." As hostilities increased towards loyalists, Gardiner gathered together 2000 pounds and fled to Halifax. All of his land in Maine was sold at auction by those "ungrateful rebellious thieves."

After residing in England, Gardiner returned to his birthplace, Newport, Rhode Island, in 1785 to set up his practice and try to regain some of his lost fortune. Though Gardiner died a year later at the age of 78, his heirs inherited a large portion of his original holdings, which accounts for some of the philanthropic endeavors, such as the Gardiner Museum in Boston.

There is some dispute as to the first hospital in America. Aside from the Pest Houses which were established in the early 1700's, Pennsylvania Hospital in Philadelphia is considered the oldest surviving institution. It was established by Dr. Thomas Bond and Benjamin Franklin and occupied a small rented house from 1752 to 1756 when a new building was completed. Though hospitals were specifically erected for the poor, the homeless and the stranger as well as the insane, this hospital was a step forward from those that existed on the continent. M. de Warville, a distinguished Frenchman, wrote in 1788:

> "I have seen the hospitals in France, both at Paris and in the Provinces; I have known none of them but the one at Besancon, that can compare to this at Philadelphia...Every room is lighted by windows placed opposite which produces plenty of light.
>
> Blacks are here mingled with whites...Each one of the lunatics (about fifteen) has a cell, with a bed and a table...I observed none of the (lunatics) were naked or indecent - a thing very common with us."

New York Hospital was established in 1773. The Massachusetts General did not open until 1821.

Though the quality of medicine increased during the French and Indian Wars due to the highly qualified medical staffs that accompanied the English troops landing in New York, the burgeon-

ing nation was unprepared for the Revolutionary War. Aside from the high death rate of physicians on the battlefield, eleven surgeons and surgeons' mates died at Bunker Hill, the infighting between the Director General and the Chief Surgeon was untenable.

The first Chief of the Army Medical Service was Dr. Benjamin Church, who graduated from Harvard College in 1754 and studied medicine under Dr. Charles Pynchon. He was one of the most respected physicians in Boston. As Chief, he was paid $4.00 a day and his task was to "furnish all medicine, bedding and all other necessaries and to pay for the same." Even in those days $4.00 was grossly inadequate. In less than a year, Church was held for treason, having been accused of consorting with the enemy, seeking additional supplies. He was found guilty, and sentenced to solitary confinement. After a year of confinement, he was granted permission to leave the country and so he sailed for the West Indies. The ship was lost at sea.

When Dr. John Morgan became the next Chief of Medicine, a new post had been created, the Army Chief of Surgery. Both departments shared the meager funds made available which led to constant agitation. Morgan resigned in 1777 and was followed by Dr. William Shippen Jr. who preferred to remain in Philadelphia and send instructions via courier. In 1781, Shippen was tried and found innocent of misconduct. Dr. John Cochran followed Shippen and served until the end of the war. In September, 1783 Congress granted furloughs to all medical staffs. The Army Medical Department was not revived until 1818.

Actually there was very little an army doctor could do. The major duties were to pull teeth, set fractures in horses as well as men, excise tumors, remove a ball and remove a baby by Caesaren section after the death of the mother. One interesting incident is recorded in the annals of the medical department of the Revolutionary War. In 1781, Dr. Charles Gilman who was serving at the Battle of Haarlem Heights, received a deep cut on his hand which would not heal and which continued to fester. One night, while drinking rum, he accidentally spilled the remains of the bottle on the wound. The following day he noted the wound was healing. He continued to apply a little rum each day. There after all wounds were soaked with rum cloth before covering.

Though some advances were made during this period, such as the first flexible catheter designed by the remarkable Benjamin Franklin, who also in-

*Continued on next page*

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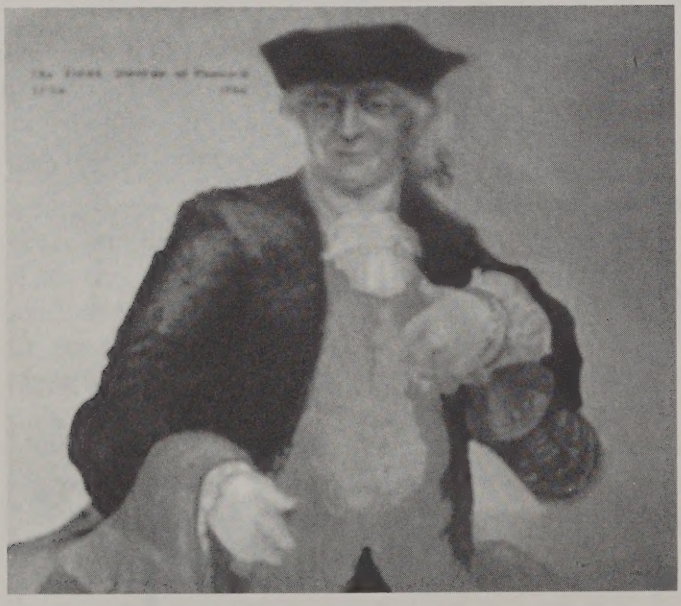
# Medicine Through The Years

*Continued from previous page*

vented the bifocals in 1784, and the first written report on a case of extrauterine pregnancy by Dr. John Bard, medicine was still pretty much limited to outward observation.

The most poignant example of the practice of medicine during the latter part of the eighteenth century is the case of retired General and President George Washington. One night after retiring as President, he woke with chills and a sore throat. Three physicians were called. Four pints of blood were drawn from his body, followed by the administering of vapours of water and vinegar, ten grams of calomel and several doses of tartar emetic. Hot bran and vinegar poultices were applied to his throat as well as to the soles of his feet. In less than twenty four hours George Washington was dead from what is believed to have been a streptococcal infection of his throat. ■



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The total amount donated thus far is $1,035.00. Our goal is $3,500.00 so don't delay, have your name appear in this list when the next Hippocrat comes along. Just make your generous check payable to PHYSICIANS PORTRAIT FUND 1986 and mail it to Dr. James Fitzpatrick, Springfield Academy of Medicine, 1400 State Street, Springfield, MA. 01109

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**This is the last installment in this series. As new HMO's and PPO's appear in our area, relevant data will be published in the Hippocrat.**

## IV. HMO's AND PPO's AVAILABLE IN THE PIONEER VALLEY

The number of HMO's and PPO's being offered to employers is increasing at a rapid rate throughout the country. There are now two HMO's and one PPO in the Pioneer Valley. The Health Care Coalition is aware of activity underway in the Greater Springfield area for further HMO and PPO development.

This section provides descriptions of the programs currently operating and available to employers in the Pioneer Valley.

### 1. The Valley Health Plan

Valley Health Plan is a non-profit, federally qualified and state licensed HMO. Now in its eighth year of operation, this "group model" HMO provides comprehensive medical services to members in three locations. Valley Health Plan contracts with Amherst Medical Associates, a multi-specialty group practice, to care for members at the Amherst Medical Center (Amherst). The employees of the Commonwealth of Massachusetts may choose to be served by the health center at the University of Massachusetts (Amherst). Arrangements have been made with the Cooley Dickinson Hospital, Amherst Nursing Home, and various Visiting Nurse Associations to provide institutional care to VHP members.

Valley Health Plan has about 22,000 members. Employees of 220 local employers and of the Commonwealth of Massachusetts account for the majority of memberships, with federal employees, Medicaid recipients, and non-group members making up the remainder. Valley Health Plan emphasizes consumer control and service to members. Nine of VHP's Directors are community representatives who are not health professionals, seven of whom are elected by the Plan membership.

WHAT IS COVERED

Valley Health Plan offers a range of benefits similar to most federally qualified HMO's. All inpatient services are covered in full with these exception: psychiatric admission is covered for 60 full days; alcoholism/drug rehabilitation is covered for 30 full days; and blood or blood derivatives are excluded. Outpatient services for members are covered in full for office visits, diagnostic services, x-rays, lab services and surgery. Copayments are required for house calls within the service area ($5), prescription drugs and medicines ($1); and eye examinations ($15); as well as out-of-area urgent or emergency care ($50). Twenty-four hour crisis intervention for mental health is covered in full. Psychiatric consultation, individual counseling and psychotherapy, group therapy, and marriage/family counseling are covered in full for the first 10 visits; the next 20 visits have a $15 copayment per visit. Family planning, home health care, materni-

*Continued on next page*

# Alternate Delivery Systems Buyer's Guide

*Continued from previous page*

ty, and well-child care are covered in full. Dental services for children to age 12 are covered in full for up to two visits per year for examination, prophylaxis, and fluoride. Emergency treatment for accidental injury to sound natural teeth is covered in full for all members. An employer who wishes to purchase VHP coverage at a reduced price may choose to eliminate the prescription drug coverage, or to have office visits cost $3 each (instead of no charge.)

HOW IS IT OFFERED

An employer with five or more employees is eligible for group VHP coverage. Contacting a Subscriber Representative in the VHP business office is the best way to begin exploring this option for employees. Valley Health Plan premiums are developed on a community-rated basis and are generally guaranteed for 12 months. Once a contract is in place, VHP encourages a two to four week enrollment period and will furnish informational speakers, posters, etc. An individualized benefit comparison sheet and enrollment packet can be produced. Employees who sign up during this initial enrollment period are accepted without waiting periods or pre-existing conditions exclusions. After the initial enrollment, only employees newly eligible for benefits may sign up for Valley Health Plan membership. Then, once a year the employer may again open up enrollment and employees can switch coverage at that time. VHP is one of the few HMO's in the country which allows non-group enrollments. Each year the Plan holds a Community Enrollment. Individuals who apply through Community Enrollment are offered the same benefits at the same price as group coverage, but most fill out a health history and can be rejected for membership.

THE FUTURE

In July, a new Greenfield Health Center will be available to members -- a joint project of

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Pioneer Family Physicians and Valley Health Plan. Also in July, a comprehensive dental plan will be offered to employers who wish to improve the dental component of their VHP coverage. Later in 1985 VHP Eldercare will be launched. Eldercare will be an option for individuals who would like to receive the coordinated and extensive care Valley Health Plan can provide, in place of the limited benefits of Medicare A and B. Employers who contribute towards the health coverage cost of retired employees may achieve significant savings through offering Eldercare to interested retirees.

**2. Medical West Community Health Plan, Inc.**

The Medical West Community Health Plan, Inc., a Federally Qualified staff model Health Maintenance Organization (HMO), is a not-for-profit Chapter 180 member Corporation which is licensed pursuant to the applicable statues of the Commonwealth of Massachusetts.

The members of the Corporation are Blue Cross of Massachusetts, Inc. and Blue Shield of Massachusetts, Inc. The Plan was created and received licensure as an HMO in late 1978 to-provide prepaid services within the Greater Springfield, Holyoke, Chicopee and Westfield area. The Plan initially provided services within its own 39,000 sq. ft. facility located at exit 5 of the Massachusetts Turnpike in Chicopee.

Because of the Plan's wide acceptance by area employers and employees, the Plan's membership now exceeds 58,000 and the main facility in Chicopee has been expanded to in excess of 63,000 sq. ft. In addition, the Plan opened a 16,000 sq. ft. health center facility on Bicentennial Highway in Springfield in late 1984 and is now embarked on another expansion plan. It is anticipated that the Plan will open a new Health Center consisting of 13,000 sq. ft. to accommodate approximately 9,000 members. This new center will be located on Main Street in Agawam. The Plan's current facilities are also expected to be enlarged in the near future to accommodate the Plan's protected growth in the years ahead.

Since January 1, 1984 Medical West has been one of the four (4) Blue Cross/Blue Shield HMO's which has provided prepaid services to Medicare beneficiaries. Known as the "Senior Plan," almost 3,000 individuals were enrolled in the first year of operation and Medical West has just concluded negotiations with the Federal Government to not only continue the Senior Plan, consistent with the new Federal Regulations, but to appreciably expand its membership in the years ahead.

**3. Pioneer Health Care, Inc.**

The Pioneer PPO is a hybrid of the entrepreneurial model. The organizational structure consists of two separate corporate entities: Pioneer Health Care and Pioneer Management Systems. Pioneer Health Care is the preferred provider panel of physicians, hospitals and other health care providers. It is a nonprofit corporation governed by a Board of Directors made up of seven local physicians and two non-physicians. Pioneer Management Systems, a for profit management services company and a subsidiary of National Medical Enterprises, has developed Pioneer Health Care and is responsible for the day-to-day administration of the program.

The heart of the Pioneer PPO is its Cost Management Program. The program includes provider contracting with discounted reimbursement rates, pre-admission hospital certification, admission and length-of-stay hospital profiling. Pioneer will also provide insurance companies and employers with Management reports which identify the effectiveness of utilization review, and the savings attributable to participation in the PPO.

Pioneer Health Care is available to individuals and their families through their employer, union health and welfare trust funds, and/or association plans. Participating groups are assessed a flat administrative fee based on the number of eligible individuals.

Pioneer expects to market the PPO through commercial insurance companies which agree to sell Pioneer as part of their ongoing marketing activities. ■

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# Gov. Dukakis--MMS Medicaid Agreement

*As you are all aware, on September 16, 1985, MMS and Governor Dukakis signed an agreement to help improve the function of the Medicaid system in this state. MMS agreed to recruit 85% of all actively practicing physicians and to develop a referral system for Medicaid participants on a statewide basis. These two aspects of the agreement have been widely covered in the press. Less widely covered are the following which are printed verbatim.*

II. THE MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE WILL:

A. PROVIDER AGREEMENT:

1. Replace the separate provider agreement with agreed upon certification language printed on the MMIS claims form for physicians who submit paper claim forms to the Department;
2. Replace the separate provider agreement with agreed upon certification language printed on the tape or disk transmittal form for physicians who submit claims by computer tape or disk (paperless) to the Department;
3. Notify physicians that the existing provider agreement will be superseded effective with the signing of the certification language as described in items 1 and 2 above.
4. Issue notice to all Medicaid non-participating physicians that they may bill and be retroactively reimbursed for all medical services previously billed and unpaid to April 30, 1985; and
5. Issue notice that as of May 1, 1985 participating physicians will perform services and be reimbursed under the conditions of the agreed upon provider agreement until such time as the MMIS claims form is printed and distributed with the new certification language.

B. CLAIMS PROCESSING:

1. Implement changes in MMIS procedure/diagnosis code programs by employing a medical coder to review and resolve procedure/dianosis code conflicts;
2. Implement identified and needed improvements to the MMIS data base reconciliation (self-correction) process;
3. Implement Medicaid eligibility data base corrections;
4. Implement needed MMIS claims error messages to identify Medicaid recipients by name and identification number;
5. Implement identified and needed systems changes to improve recipient eligibility verification processes (e.g. additional staff and telephone lines);
6. Implement MMIS systems changes to allow expeditious processing of 90-day waiver claims;
7. Implement identified and needed MMIS systems changes to decrease suspended claims from 60 days or longer to 30 days;
8. Adjudicate all physician MMIS claims suspended for one year and longer:
9. Implement necessary Medicaid systems changes to begin conversion of current MUMPS coding scheme to accomodate the universally accepted procedure coding system - CPT IV;
10. Examine necessary Medicaid systems changes to consider conversion of current MMIS claims form to accommodate the universally approved and accepted health insurance form - HCFA 1500;
11. Implement a formal MMS/DPW staff liaison activity to identify claims problems, payment problems, and audit problems and implement changes as needed;
12. Implement a program of on-site (physician) staff assistance to correct and eliminate MMIS claims processing problems;
13. Implement a schedule of statewide formal MMIS claims completion retraining workshops for Massachusetts physicians and office managers;
14. Implement marketing, publicity and on-site educational efforts to encourage physicians to utilize paperless claims submission systems, e.g. computer tape to tape or disk to tape techniques; and
15. Develop recipient eligibility verification SMART card to reduce/eliminate unnecessary and inappropriate claims denials.

C. AUDIT PROCEDURE:

1. Implement a statewide schedule of onsite

educational assistance programs about Medicaid audits to physicians and their office managers;

2. Establish the Medicaid postpayment audit period as 18 months or less;
3. Analyze SURS reports and seek technical imput from MMS to develop future Medicaid audit plans;
4. Implement the correction and/or modification of MMIS prepayment edits that routinely result in retrospective audits;
5. Implement targeted audits of physicians selected through SURS process or referrals;
6. Implement needed audit system changes whereby Medicaid auditors can credit underpayments to physicians as an offset against Medicaid overpayments;
7. Implement procedures to offer physicians the option of extrapolation or 100% audit when audit sample size and physician specialty permits;
8. Schedule on-site postpayment audits using SURS for Phase III -- analyze data and review alternatives with MMS; and
9. Initiate MMS/DPW joint actions/decisions to implement recoupment parameters for low-end error rates.

III. THE EXECUTIVE OFFICE OF HUMAN SERVICES WILL:

A. Actively recruit non-participating, non-Massachusetts Medical Society member physicians for Medicaid participation;
B. Establish Medicaid participation targets and actively recruit all Massachusetts HMOs, Walk-in Medical Centers, Community Health Centers, and Hospitals for participation in Medicaid to strengthen statewide access efforts;
C. Regularly report to MMS to update statewide Medicaid participation telephone referral network with new identified participating Medicaid providers:
D. Sign EOHS/MMS Medicaid referral letter;
E. Distribute publicity materials to announce Massachusetts Medical Society Medicaid access telephone referral system;
F. Implement managed care programs in Massachusetts for Medicaid recipients using Massachusetts Medical Society technical input and resources; and
G. Implement a cost effective ambulatory surgery pilot program (Physician's office) with professional and facility reimbursement structures for the Massachusetts Medicaid program using Massachusetts Medical Society technical input and resources.

IV. THE EXECUTIVE OFFICE OF HUMAN SERVICES/RATE SETTING COMMISSION WILL:

A. Conduct ongoing reviews with the Massachusetts Medical Society prior to implementation of the Rate Setting Commission-Medicaid proposed relative value scale reimbursement system in order to maintain and strengthen recruitment of physicians to participate in the Medicaid program; and
B. Work jointly with the Massachusetts Medical Society to review the technical and economic impact of Medicaid physicians' fees and proposed relative value study. ■

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# A Different View of the Malpractice Crisis

While there is no "solution" to the present malpractice crisis, it may be worthwhile to examine options not much considered to date. The tort reform package sponsored by the MMS now under consideration by the legislature has little chance of passage except for those bills that impact only on physicians. A similar program being prepared by the governor's office has an equal chance of enactment. Why the governor's office has apparently ignored the efforts of the MMS is perhaps an indication of how things will go in Massachusetts. If any relief comes, great. We should not count on it.

There are, in my opinion, areas where we, as physicians, can bring about meaningful change in the malpractice allegation arena.

Malpractice allegations are heard first before a tribunal that judges possible merit, and many years later in jury trials. Many cases are settled by the JUA. Some are dropped along the way. The cases that go to a jury trial are decided one way or the other, usually on the basis of the testimony by the expert witnesses. The persuasive skills of the attorneys involved and the sympathy generated by the patient plays a dominant role in the outcome of many trials.

We are told that 60 - 80% of trials are decided in favor of the physician. Many cases are however settled out of court. The unpredictability of the jury system and the cumulative aggravations associated with drawn out litigation serve as a stimulus to settle many cases.

It is my opinion that the present situation can be modified by actions of physicians. This essay will attempt to outline some possibilities.

It is my observation that in the run-of-the-mill malpractice case both the defense and plaintiff's attorneys are not as well prepared as they could be. Most preparation on both sides takes place in the weeks and months immediately prior to the trial.

There is usually a tactical advantage on the side of the plaintiff in that the expert witnesses are physicians who testify in that role over and over again. The experience of dozens of cross examinations is significant. The defense expert witnesses are often in a one time situation. The best preparation may not be sufficient to withstand a vigorous cross examination by a talented trial attorney. The same question asked over and over again often brings out an apparent inconsistency that can reduce credibility.

Our courts do not operate in a predictable, orderly manner. The time of appearance of an expert witness is not certain. Delays of all sorts occur. The plaintiff's witness is usually heard early in the trial, and can be given reasonably sure time to appear. The defense witness appears near the end of the trial and must be on call for many days (or weeks) before testifying. This uncertainty is very disruptive to the physician in private practice and has caused a large number of physicians to avoid involvment in court proceedings. Some plaintiff's attorneys are said to intentionally modify the trial schedule in hopes that the defense witness will not appear. An obvious remedy would be an agreed upon schedule between both attorneys and the judge for time of appearance of expert witnesses, and for time allowed for both direct and cross examination. Many more physicians would be willing to appear as expert witnesses if the time involved was predictable.

The present JUA approach to most cases is to have one physician review a case and to agree to appear as an expert witness if he feels the case should be defended. Other reviewers may become involved

This system could be improved. A panel of interested physicians should be established to review cases before they go to tribunal, and to work with the defense bar in planning and orchestrating the defense. The very best possible defense witnesses should be enlisted long before the trial. Defense witnesses should be given the opportunity to observe the plaintiff's attorney in action in court. All defense testimony should be critiqued by both physicians and attorneys. A small number of physicians should appear regularly as defense witnesses to gain confidence and experience in this role. Compensation for this time should be at least equal to that of the physician's usual practice income.

By improving physician participation and effectiveness in defense, fewer cases would have to be settled and more that go to a jury trial could be won. This would discourage the plaintiff's bar from initiating many unfounded suits.

Today, physician performance is reviewed in all areas except court testimony. To my knowledge, there is no qualitative review of court testimony in any context--civil, criminal, malpractice, personal injury, etc. The jury alone decides.

We physicians can and should review testimony of our peers. All court testimony is public knowledge. All testimony of physician

witnesses for both the plaintiff and the defense side should be reviewed and judged by knowledgeable physicians. Where testimony is not factual or misleading, this should be noted and be made available to disciplinary bodies including medical staff of hospitals where the witness has admitting privileges. Flagrant examples of untruthful or misleading testimony should be published verbatim, with the physicians concerned being clearly identified, in one of our MMS publications.

I am advised that some physicians who regularly appear as plaintiff's witnesses do so primarily for economic reasons. Medical School faculty members apparently are not required to count witness fees as part of practice income that is limited by the medical school. Our state society should attempt to persuade the medical schools to change their employment arrangements to include witness fees as part of practice income.

It is clear that society will compensate patients who are truly injured from negligent actions or omissions of physicians. The bulk of malpractice allegations involve either no true injury or no true wrongdoing on the part of the physician. Here, in the morass of our judicial system, we can do better than is now the case by physician action and involvment.

Greater physician involvement could lead to greater discretion in the selection of defense council based upon prior performance. The defense bar should be put on notice that each case deserves a maximum effort. Anything less would not be tolerated.

A change toward militancy on our part leads to the question of counter suits. All writing on the subject by the legal professions discourages such suits. I disagree. There is no reason that the huge sums collected by the JUA cannot be used to finance and to leverage quality legal talent in this arena. It would not be necessary to have an early victory here, since one could expect endless delays and appeals in these suits. The mere presence of well financed aggressive counter suits could exert a much needed "sentinal" influence upon the bringing of less than meritorious allegations against physicians.

All of what I suggest could be criticized as being expensive. In the long run a change in attitude could cost less. After all, all the money involved is our money. ■

Lorne C. Smith, M.D.

(Dr. Smith has served on a tribunal, reviewed cases for the JUA, and has appeared as a defense witness.)

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# Conversations With a Wizard

While walking in the woods the other day, I stopped and perched on a stump by the bend in the path. The sky was clear and the sun warm, but there was just enough of fall in the air to keep most bugs at bay. Nevertheless I spotted a recalcitrant Deerfly on Shadow's rump and swatted it as he ambled by. With his own tacet form of gratitude he marked the stump instead of my foot in his peripatetic territorial circumscription.

I wondered if Hornbeam would be out and about on such a lovely day, and as if on cue I heard a twig snap and spotted a movement off in the woods. Moments later he came striding up the path, star studded cape swirling in the wake of his passage.

"Well met," he beamed, "how's quackery?"

"Fair to middling," I muttered, "how's tricks?" - He scowled - I knew he hated this term, but could never resist the temptation -"wizardry?" I corrected lamely.

"Can't complain," he conceded.

Now Hornbeam is a Wizard. Quite how he came to be living under the mountain in back of my land, I have no idea. Of course, Hornbeam maintains that I built my house in his front yard, but then wizards are known for their egocentricity.

I don't know how long Hornbeam has lived in his cave, but over the years I'd seen the halt and the lame come to be magicked and leave with smiles on their faces and a spring in their step. Some they brought on litters, Hornbeam would try his strongest spells, and sometimes even these folk walked away, but those who had gone beyond the pale he wouldn't touch. They came in caskets and left the same way.

"There are limits, you know?" he'd say, with that knowing smile of one healer to another.

I looked up to find him watching me quizzically. "Trouble in the ranks?" he asked.

"You could say that" I replied, relieved for the chance to talk to someone. "For one thing there's burnout."

"Jezz." he exclaimed - an expression I was sure he'd caught from me, since it had not been part of his previous vernacular - "I knew a fellow once did that. He worked all day on his Philosopher's stone, trying to turn lead into gold. Wouldn't eat or sleep or anything, till one day he must have got it right. Charred himself himself something terrible - but everything around him was gold!" He looked at me grinning - it wasn't funny

"They say there's too many Doctors out there "I said, scowling at him.

He pondered awhile. "We had that once as well - a few hundred years back. There were so many wizards, folks figured that they could get their magic cheap. Soon none of the young fellows wanted to be wizards and then there weren't enough and people had to go unmagicked. They tried bringing sorcerors from abroad, but it didn't help. Those were bad times." He stroked his chin, eyes lost in his memories.

"Well at least you don't have to pay malpractice!" I exploded, hoping finally to strike a raw nerve. Hornbeam was always like this, he'd been around so long that he'd seen almost everything bad that could happen.

Hornbeam looked puzzled. "Well, I had to make a tithe to Thor the other day, and the Druids used to tax us something awful, but I've never heard of this."

Delighted to find something that he couldn't better, I explained, but still he looked bewildered.

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"Now let me get this straight," he said. "Folk come to you to get magicked, and then when the auguries are wrong they expect you to pay them off? So you pay protection to keep them and their Pettyfoggers away?"

"Well not quite," I began, wanting to correct him, but somehow he'd caught the essence. He'd learned more of my world than I'd realised.

"Is it because you magic them wrongly?" he asked, invoking a protective spell. "It can happen. I've known some bad ones in my time." He straightened his cap looking somber.

"Sure, sometimes that's the problem, but mainly the people think that Wizards - I mean Doctors, have insurance so they can get something for free - a free lunch we call it."

"And I bet the pettyfoggers get lunch as well" Hornbeam snorted indignantly.

"Well certainly, lawyers fees are contingent on the settlement," I said, trying to keep a balance in this discussion.

"But what if you did your best?" He looked puzzled. "Don't they understand that sometimes the portents are wrong and spells don't work the way they should?"

"Nope"

"But who is it says your magic went wrong?"

"The lawyers bring in experts who say it should have been done differently."

"But how can they say that?"

"They're experts."

"Who says?"

"They do."

"So then they're accountable for what they say, right?"

"I'm afraid not."

Hornbeam snorted in disgust. "And you have to pay for this. Don't folk know that it comes out of their purses in the end?"

I shrugged.

"Practice used to be simple," I said. "Once upon a time, one did tests to find answers. Now we do tests to ward off -" I hesitated - "the pettyfoggers, and then the government and everyone else blames us for running up costs. Now they've frozen fees, but still we have to accept welfare patients or they won't give us a license. It's gone crazy!"

This was too much for Hornbeam. He stood up, piercing blue eyes blazing with anger and, wrapping his cloak around him, strode off down the path. As he turned the bend, there was a swirl of stars amoung the leaves as he disappeared, and faintly I heard him say, "If you like I'll teach you wizardry."

What bothered me most was not the offer, but the fact that for a moment I seriously considered accepting. I thought about those I'd seen driven from practice into early retirement, insurance medicine, research or into non medical fields. I wondered about those who had suddenly decided it was us who were wasting their money, and wondered if somewhere I'd missed something. ■

Nicholas P. Coe, M.D., FRCS.

# Special Notice

The First Annual Symposium in Geriatric Medicine will be held November 20, 1985 at the Quality Inn, Chicopee, MA from 1:00 - 5:00 pm.

This program is being jointly sponsored by Springfield Municipal Hospital and the Postgraduate Medical Institute.

The featured speakers will be Dr. Alan Siegal presenting, "Alzheimers Disease, A Clinical Update: 1985; Dr. Andrew Weinberg presenting on "Depression in the Elderly;" and Dr. Alan Sholomskas presenting on "Depression in the Elderly." These presentations will be followed by a panel discussion.

This program has been accredited for three Category I credits for physicians.

For more information, contact Susan Kucharski, RN at 787-6700, ext. 6663. ■

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# The Final Epidemic

"The most serious threat to health in the world, in history, is nuclear war. One could hardly do anything more important in the area of preventive medicine than try to prevent nuclear war."

This statement, written by Dr. George D. Lundberg, editor of the Journal of the American Medical Association, reinforces the official AMA position that there is no adequate medical response to nuclear war. For the third consecutive year, the Journal has devoted an entire issue to this grave danger. On an even larger scale, members of the International Physicians for the Prevention of Nuclear War (IPPNW), representing the major world powers, have amended the Hippocratic oath to reflect their conviction that "a nuclear war would be the final epidemic for mankind." The amendment reads, in part, "As a physician of the 20th century,....I will do all in my power to work for the prevention of nuclear war."

Physicians can become involved in the prevention of nuclear war by working with groups such as the IPPNW or Physicians for Social Responsibility. Another option, which I feel is extremely hopeful is the Beyond War Movement.

Beyond War, a nation-wide grass roots educational movement, was formed three years ago in response to the threat of nuclear war. The goal of Beyond War is first to inform people of the awesome threat to our survival. The world's nuclear arsenals now contain the explosive power of one million Hiroshima bombs. While many of us have read about the horrors of a nuclear war or seen it portrayed in the movies or on t.v., most of us still do not fully comprehend that we now face the very real possibility of extinction. Equally important is the second goal: The need to communicate a sense of hope. For while our situation is critical, it is not hopeless. Beyond War provides an opportunity to discuss, develop and demonstrate a new way of thinking which can bring about a world beyond war.

The basis for this new way of thinking is the clear understanding that all people share one interconnected, interdependent life support system. We live together on one earth. We are one. Moreover, our technological genius has now made


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war obsolete. Our weapons no longer threaten just tribes or cities; they now endanger the whole planet and every one of us.

Beyond War is not simply an "anti-nuclear movement." It focuses on dealing with the root cause behind this arms insanity: The use of violence to intimidate or subdue a perceived enemy. Since any war could potentially escalate to a nuclear war, all war is obsolete and, therefore, we must now seek other means to resolve conflict between nations and people. Further, the root cause of war is not economics, nor social systems, but the way we as humans think about conflict. This knowledge gives us hope because we know that it is possible to change the way we think. We have, over time, changed our thinking about human sacrifice, human slavery and human rights.

The Beyond War movement works locally, nationally and internationally. Concerned people of all walks of life are working to build a world beyond war in 30 states and six foreign countries. To assist in this educational process, Beyond War produces films, videotapes, curricula and other materials. One film "No Frames, No Boundaries," has been translated into five languages and received The Freedoms Foundation Award for excellence. In the Springfield area there is an actively growing group of people who have become involved in the educational process of Beyond War. There have been ongoing introductory meetings held at Mercy Hospital over the past several months and the response has been enthusiastic. Since many people have become interested in learning more, we have started holding 3-part orientation series to a World Beyond War.

While everyone should be concerned with these issues, physicians should naturally lead the way since the goals of our profession are totally consonant with the goal of preservation of life on the earth. We must accept our responsibility to all of humanity and do all that we can to build a world beyond war.

To learn about what you can do contact me at my office at 300 Stafford Street in Springfield, MA 01104, 734-5564, or attend an introductory meeting October 9, October 30, or November 13, at Mercy Hospital at 7:00 to 9:00 p.m. ■

"Mankind must put an end to war or war will put an end to mankind."

John F. Kennedy, 1961

"The unleashed power of the atom has changed everything save our modes of thinking and we thus drift toward unparalleled catastrophe."

Albert Einstein, 1946

"Because everything we do and everything we are is in jeopardy, and because the peril is immediate and unremitting, every person is the right person to act and every moment is the right moment to begin, starting with the present moment."

Jonathan Schell
The Fate of the Earth

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# Medical Ethical Dilemmas

On September 11, 1985, several hundred nurses, social workers, and physicians attended the seminar sponsored by our Hampden District Medical Society Medical Religious Committee. Dr. Jim Fitzpatrick and his committee of physicians and clergy are truly to be congratulated for an enlightening evening.

During the first part of the program Professor Arthur Dyck, the Professor of Population Ethics at the Harvard School of Public Health, outlined his approach to the dilemas of medical ethics. During the second half of the evening there was a round table discussion. This report will be primarily limited to the remarks of Professor Dyck,

Professor Dyck began by defining the parties involved as follows: first that ethicists are well aware of the skills and dedication of the medical profession, second that ethicists fully realize that ethics are part of our common life, and thus ethical decisions must be shared by all, and third that patients are moral agents with a wide degree of variation in their capacity to understand their own needs and problems. Professor Dyck then went on to further define his presentation by stating that he would examine the ethical relationship between the patient and physician under three headings: first compassion, second the covenant, and third the community as they relate to this relationship.

Compassion was defined as a deep sympathy for the trouble of others accompanied by an urge to help and, a corollary to this, that in acting to help we must refrain from injuring others—first of all do no harm. To begin, he defined for his audience constitutive rules as those rules without which there can be no other rules. For instance, traffic rules, rules of games, etc., work because we assume the constitutive rule that people won't cheat. A constitutive rule against killing allows us to walk around unarmed in most societies. Underneath all contracts, goverment regulations and laws are our deep proclivities not to cheat, to tell the truth, and to respect one another. These rules are logically and morally requisite for sustaining communities and individual lives. The rule first of all to do no harm is one of these constitutive rules. But, if we are committed to compassion, we are also committed to the finest of technical medicine. Compassion is not on a collision course with skill—if first of all I am to do no harm, then I must be extremely skillful.

Next, he considered the decision making process. He reminded us that decisions are constantly being made, sometimes subtly and sometimes not so subtly, as to what research problems to solve and/or who shall be saved. He gives an example in his ethics class: there are only limited technical resources to save two equally sick children dying of the same disease. One a poor student and a poor athlete from a broken family and the second an excellent student and champion horseback rider from a happy family. Although the example is presented in a much less obvious manner, the class invariably chooses to save the excellent student from the happy family, when there is clearly no medical reason to arrive at such a decision. However such decisions are constantly made; a blind deaf newborn can be looked upon as another Helen Keller or as a hopeless case.

At this point Professor Dyck entered into a discussion of issues such as the right to die, euthanasia, and living wills. Not killing is a linch pin of all societies, but is it sometimes merciful to kill? A small number of persons who are dying in hospices ask to discuss the possibilities of euthanasia, but it is a common experience that once pain and isolation are relieved, no further discussions occur. People who are dying are still living. There are some, however, who do not wish to distinguish mercy killing from our willingness, and sometimes our obligation, to refrain from using technologies that are neither desired nor considered helpful to persons dying from irreversible illness. What is the moral difference between actively taking one's life and passively letting him die? In some cases there is no difference. But, if a person is irreversibly dying, there is a difference. You cannot kill him, but you can relieve the pain and suffering even if it will hasten the time of his death from his lethal disease.

A more explicit issue being currently debated is that of withholding nutrition. Some courts have stated that you could withhold nutrition from a person with a shortened life expectation usually defined as a year or less. A number of legal cases have involved the use of nasogastric tubes, IV feedings, gastrotomies, and the like. The courts have stated they may be removed if physician and family agree because it is a technical medical procedure. There are others that argue that feeding is a basic life support action and to withhold it is much more than withholding medical care. The courts find difficulty in deciding this debate, but Professor Dyck believes this is a non-debate and

grants both propositions. Now the issue becomes whether you are really starving the person to death or is the patient dying of his/her disease. If the person is really dying of the disease then the insertion of a nasogastric tube may be painful and not done. The important point being you may allow the person to die of his disease, but you may not starve the person. In the process you should not cause the person pain.

The second aspect of the physician-patient relationship is the covenant. The physician owes it to himself and to the moral requisites of our community to treat patients as moral agents, having the ability to make their own choices. We must supply the information for the choices to be made. We must give the patient our honest advice, but must also treat the patient as our moral equal. There is no place for lying in the relationship between moral equals. No matter what we consider the value of the efficacy of lying over the efficacy of the truth in a particular clinical situation—that is not the issue. The issue is what is the morally appropriate relationship with your moral equal. Deception is a break in that relationship. You may lie to your enemy, because that relationship is already broken, but you may not lie to your moral equal. You must have a morally impeccable relationship with your patients.

The third aspect of our ethical relationship with our patients which Professor Dyck discussed is the effect of the community on that relationship. Who should decide the value of life, and on what basis? In the courts the right to privacy has been promulgated to say that only the individual can determine the value of his/her own life—the basis of living wills. But, are we all autonomous or are we interdepent?

Historically, the fact that we have all been born and nurtured by our mothers, instructed by our teachers, protected by our government, our families, our police, and even our physicians, has pointed to the conclusion that we owe at least a portion of our lives to the community that has nurtured us. This leads to the question is it morally acceptable for the individual who has been nurtured and protected by his community to decide "What to do with my life is solely up to me?" This is what is used to defend the right to suicide and the notion of the right to privacy which is used in deciding whether "my life" has any "new worth." When deciding what is in the best interest of the patient, we are beholden to consider what is in the best interest of the community as well. We all have the responsibility to see to it that things make our lives possible together stays together and remains there.

Professor Dyck concluded his discourse by presenting ethically acceptable criteria for deciding moral and medical dilemmas. These criteria have been discussed by ethicists for many centuries, but must be rediscovered from time to time. The first seven were written as the "Nuremburg Code" and the last was added by the NIH.

EIGHT CRITERIA FOR DECIDING CONFLICTS AND ACTIONS WHERE HARM MIGHT RESULT.

1. Just cause
2. Just intent
3. Just means
4. Due proportion, balance between harm vs. benefit
5. Hope of success
6. Last resort--no better solution
7. Public declaration (informed consent)
8. Proper authority (training, licence, etc.)

Following a short break there was a panel discussion in which there was very active participation by Reverend Bruce Benander, Robert Kasper, M.D., Attorney Ted Brown, Rabbi Jerry Gurland, and Father John Tuohey. The flavor of the spontaneity, liveliness, sincerity, and interest of both the audience and the panel discussion participants would be impossible to capture in a report such as this. I would only hope that you would all attend the next time you have such an opportunity.

Apologies to Professor Dyck. I have done my best to capture the meat of his presentation and I sincerely hope I have not distorted his message too greatly. ■

Reported by,
Terry D. Ryan, M.D.

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# No Way to Lower Health Care Costs

By Frank J. Veith

So-called prospective payment programs, which fix the number of hospital days or the cost allowed for a given illness, are now being touted as the latest panacea for the nation's soaring medical bills. Everyone agrees that something must be done to contain costs. But prospective payment programs are a seductive—and destructive—idea.

Limiting hospital stays may lower health care costs; it may also cripple our efforts to provide proper care for the elderly and others unfortunate enough to have a complicated illness.

Certainly the elderly use a large proportion of health services. People are living longer, and within two decades the majority of Americans will be over 60. But the problem is not just that there are more old people. The simplest condition—appendicitis, a broken leg—may need longer and more complex treatment when the patient is already weakened by normal aging. More extensive procedures to ease chronic suffering may also require longer hospital stays.

Consider a group of patients with whom I work—those threatened with the loss of one or both legs from arteriosclerosis, or hardening of the arteries. In the past, most of these patients would experience severe pain, progressive loss of mobility, and eventually many would require amputation. Since most were over 65 and unable because of age and infirmity to master the use of artificial limbs, they often left the hospital confined to wheelchairs and in need of continuous care, either in nursing homes or by home attendants.

Today, the alternative to amputation is vascular surgery, which allows us to salvage the limb. My group alone has performed nearly 2,000 of these operations in the past 10 years. More than 90 percent of our patients regain the use of their legs and can return to their previous styles of life.

However, vascular surgery involves a series of complex procedures and often requires lengthy hospital stays. What will we do when prospective payment schedules limit, as they threaten to do, the dollars that hospitals can allot toward necessary therapeutic care? One result is likely to be a return to amputations; widespread and precipitous use of amputation, without even an attempt at limb salvaging, could cut hospital bills, by thousands of dollars.

However, the average age of our patients is 74 and they have an average life expectancy of five years. If, after an amputation they live only one more year, confined to wheelchairs in nursing homes, the cost of that year's care could be nearly $100,000. By contrast, the value of preventing premature dependency and loss of dignity by selecting an alternative to amputation cannot even be measured.

Certainly health care costs must be cut. But arbitrary standards of length of hospital stay do not contain costs; the costs are merely shifted and concealed. Other measures must be investigated. The rigidity of prospective payment should be tempered by a "severity index," which would take into account the special needs of an elderly patient, including extended hospital stays. We might also consider setting up an insurance fund, similar to Social Security, to cover the costs of extraordinary care.

Should the short-sighted goal of cost containment through prospective payment take priority over protection of human rights and dignity? The patient who is denied access to procedures such as limb salvage surgery and who is thereby thrust into permature dependency has his dignity violated. He and his family suffer both economically and emotionally. Physicians and nurses are forced to abdicate their primary responsibility, which is to act in the patient's best interests. As a physician, as the son of elderly parents and as someone who is aging, I am concerned that the rights and dignity of the elderly are being shattered by limited-access health care programs.

In this country, criminals are protected against "cruel and unusual punishment." Yet in health care, we are introducing a cost-control system that produces unnecessary pain and premature dependency-cruel punishment for those whose only "crime" has been to grow old. ■

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| PREMED: | Williams College 1971-75 |
| MEDICAL: | Univesity of Rochester 1975-79 |
| INTERNSHIP: | Beth Israel, 1979-80 |
| RESIDENCY: | Beth Israel-surgery 1980-81, Mass. General Hospital/Orthopedic Surgery 1981-84 |
| FELLOWSHIP: | Mass General Hospital 1/85-6/85 |
| SPECIALTY: | ORTHOPEDIC SURGERY |

Patricia M. Morris, M.D.
1233 Main St.
Holyoke, MA 01040

| | |
|---|---|
| BORN: | May 8, 1954 |
| PREMED: | Tufts University 1972-76 |
| MEDICAL: | University of Connecticut 1976-80 |
| INTERNSHIP: | St. Francis Hospital & Medical Center 1980-81 |
| RESIDENCY: | Boston University Medical Center 1981-84 |
| FELLOWSHIP: | New England Medical Center, Boston 7/84-6/85 |
| SPECIALTY: | DIAGNOSTIC RADIOLOGY |

Neal S. Lakritz, M.D.
15 Mulberry St.
Springfield, MA 01104

| | |
|---|---|
| BORN: | May 23, 1957 |
| PREMED: | SUNY at Stonybrook, NY 1974-78 |
| MEDICAL: | Albert Einstein College of Medicine, Bronx, NY 1978-82 |
| INTERNSHIP: | Baystate Medical Center 1982-83 |
| RESIDENCY: | Baystate Medical Center 1983-85 |
| SPECIALTY: | INTERNAL MEDICINE |

John J. Papale, M.D.
80 Congress St.
Springfield, MA 01104

| | |
|---|---|
| BORN: | August 17, 1953 |
| PREMED: | University of Connecticut, 1971-75 |
| MEDICAL: | University of Connecticut, 1975-79 |
| INTERNSHIP: | Baystate Medical Center 1979-80 |
| RESIDENCY: | Mass. Eye & Ear Infirmary 1982-85 |
| FELLOWSHIP: | Mass. Eye & Ear Infirmary 1980-82 |
| SPECIALTY: | OPTHALMOLOGY |

Carol S. Ishak, M.D.
759 Chestnut St.
Springfield, MA 01107

| | |
|---|---|
| BORN: | April 7, 1954 |
| PREMED: | |
| MEDICAL: | Bristol University, England 1973-78 |
| INTERNSHIP: | Weston-Super-Mare 1978-79 |
| RESIDENCY: | Hahngmann, Philadelphia 1983-84 Earling, London, 1981-83, Reading, England, 1979-80, Primley, England 1979-80 |
| SPECIALTY: | ANESTHESIOLOGY |

Howard E. Krasner, M.D.
30 Yorktown Dr.
Springfield, MA 01108

| | |
|---|---|
| BORN: | June 3, 1954 |
| PREMED: | University of Michigan Ann Arbor, Michigan, 1972-76 |
| MEDICAL: | New York University School of Medicine 1976-80 |
| INTERNSHIP: | Medical College of Virginia 1980-81 |
| RESIDENCY: | University of Cleveland Hospital 1982-84 |
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*Continued on next page*

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| November 11, 1985 | "Diagnosis and treatment of common arthritic conditions" | Caharles A. Dirbara, M.D. Associate professor of medicine. Univ. of Mass. Medical School, Worcester, MA; Chief, Rheumatology, Worcester City Hospital |
| December 9, 1985 | "Colon Cancer" | Glenn Steele, Jr., M.D. The William V. McDermott Professor of Surgery, Harvard Med. Schl., Chairman, Dept. of Surgery New England Deaconess Hospital. |
| January 13, 1986 | "Viral illness in hospitalized patients" | Scott Hammer, M.D., Assistant Professor of Medicine, Harvard Med. Schl., Infectious Disease Section. Member, New England Deaconess Hospital |

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# November 1985 Auxiliary News

The Hampden District Medical Society Auxiliary is making it's 35th anniversary, a banner year under the presidency of Virginia Walthall, her officers and board. We invite former members and medical spouses new to the area to join us in the challenges presented.

There are several on-going projects where members can utilize their talents, interests and concerns for the benefit of the communities served. Included also, are several social functions to complete a well-rounded schedule of events.

At the auxiliary board meeting on September 19, Dr. William Baker made a plea to members of the auxiliary to help in introducing a plan for giving through the United Way. The United Way is particularly interested in reaching the larger medical complexes. Call the United Way office if you can work on this project.

Please refer to the current year book for meeting dates and call any of the officers or board members listed below for more specifics.

| | |
|---|---|
| President: | Mrs. William Walthall |
| President elect: | Mrs. Peter Lynch |
| Recording Secretary: | Mrs. Alphonse Calvanese |
| Corresponding Secretary: | Mrs. Ronald Burke |
| Treasurer: | Mrs. Alan Burstein |
| Scholastic Treasurer: | Mrs. Ahmed Mouchantat |
| Committee Chairpersons: | Please refer to 1985-86 yearbook |
| AMA-Erf | Mrs. Paul Condon |

Mark your calenders and make plans now to attend the Cocktail Dance at the Yankee Pedlar Opera House on Friday, November 1 next. Joan Asinas is chairing the event and dancing to the music of "Group Therapy" will be the Rx of the evening.

December 3, our annual Christmas Tea will be held at a location yet to be announced.

We offer a positive alternative to the "Homemaker Blues."

Be informed.
Be committed.
Be a member. ■

Hippocrat Correspondent
Catherine Aborjaily

*Cut Out and Save*

# SMOKING:
## *ITS EFFECTS ON HEALTH*

- One cigarette = loss of 5½ minutes of life.
- Average reduction in life expectancy for cigarette smokers is 5-8 years.
- For a 25 year-old male, one pack/day = decrease of 4.6 years.
- For a 25 year-old male, two packs/day = decrease of 8.3 years.
- Each year 350,000 people die from cigarette cause problems. This is almost as many as died in World War II, 7 times automobile fatalities/year, and more than all drug and alcohol deaths/year.
- Cigarettes contribute to heart attacks, lung cancer, chronic bronchitis and emphysema.
- Smoking is responsible for 25% of all deaths by fire.

Cigarette smoking is the single largest preventable cause of disease and death in the U.S.

- For a person who has smoked for years the increased risk of heart attack from smoking decreases 50% after stopping smoking for one year.
- A high percentage (60-90%) of regular smokers are habituated and addicted to nicotine. Measured by the users inability to control the habit, nicotine is 6-8 times more addictive than alcohol.
- With adequate motivation and appropriate therapy, pharmacological and psychological, many smokers are able to stop, and in one study 40-70% still were not smoking one year later. There is hope if one is willing to work.
- Stopping smoking is not only good for your health, but for those around you and sets a good model for your loved ones.

# Counter Point

I noted with interest "Farewell to the SMA 12," which appeared in the August-September, 1985 issue of the Hampden Hippocrat.

I, like Dr. Higby, am in the middle of my medical career. For most of that time, I have been Director of the Clinical Chemistry Laboratory at Baystate Medical Center (BMC), where the SMA has been the most important diagnostic instrument in the laboratory, not only in terms of its contribution to markedly increased lab productivity, but also because of its impact on clinical practice. As Dr. Higby indicated, physicians learned soon after its introduction that an SMA 12 panel was more economical than any two tests on the panel done by alternative manual methods. As a result, the instrument has been used by an entire generation of physicians for screening, diagnosis and management of their patients, in the manner so well indicated by Dr. Higby.

Many physicians can well recall an occasional experience of diagnosing a previously clinically unsuspected condition, such as hypercalcemia, with the SMA 12 profile; such experiences created a positive image in the minds of these physicians regarding the usefulness of the SMA 12 profile. Furthermore, soon after the SMA 12 was introduced, articles appeared in the literature that indicated that much unsuspected disease could be diagnosed early, often before symptoms appeared, resulting in significant declines in the need for hospitalization and resultant large cost savings. Unfortunately, this enthusiasm was clearly overstated.

In the past ten years, and especially in the past two years since the advent of DRG's and prospective reimbursement, a number of literature reports have appeared which questioned the alleged benefits of SMA 12 type screens. Many of these reports have focused on the low yield of SMA 12 screens, alone or in combination with other tests, as screening procedures for hospital admissions. In 1975, Korvin et al (1) assessed the effect of a 20 test chemistry and hematology admission panel on 1,000 patients admitted to a large hospital. They found 83 new diagnoses in 77 patients that resulted from the 2,223 abnormal test results of the admission panels. On critical examination of the new diagnoses, none were unequivocally beneficial to the patient. Most were inconsequential findings or diagnoses. Durbridge et al (2) reported no significant differences in indices of patient progress among 500 patients undergoing screening on admission to the hospital in contrast to control groups without admission batteries. They noted, however, a 64% increase in the cost of additional testing to follow up abnormalities disclosed in the initial screen. MacPherson (3) stated that a 16 test hematology, chemistry and serology admission panel, developed by the lab with consultation from clinicians of each major clinical service, was introduced in 1964 at Ohio State University Hospital with the hope that it would shorten hospital stays. What resulted was an exponential rise in volume of laboratory procedures, but absolutely no change in average patient stay. He further stated that a major result of instituting this routine admission test battery was to cause physicians to repeat abnormal findings rather than using them as a basis for therapy. More recently, Kaplan et al (4) found that only .22% of the routine tests ordered as part of a preoperative laboratory screen might have influenced perioperative management.

With reference to screening of outpatients, Holland et al (5) assessed the value to general practitioners of a screening service which included hematologic and biochemical tests as well as several other programs. Five thousand three hundred fifty subjects were screened and subsequently followed up five years later. There was no significant difference in certified sickness or mortality in the screening group versus the control group. The authors concluded that "these controlled trial results have failed to demonstrate any beneficial effect on either morbidity or mortality. The authors believe that the use of general practice - based, multiphasic screening in the middle aged can no longer be advocated on scientific, ethical or economic grounds as a desirable public health measure." Studies of the efficacy of screening of outpatients have also been reported by Collen, M.F. et al (6) and Olsen, D.M. et al (7); these studies produced conclusions similar to the Holland study. Thus, as a screening or diagnostic tool, SMA 12 panels are not medically efficacious or cost effective.

Patient Monitoring and Management: Higby stated that the SMA 12 was a useful tool in his hands for these purposes. There can be no doubt, however, that this is done better and more efficiently when each physician selects his own tests or panel of tests to meet the individual needs of each

patient he is managing. For instance, the liver function tests needed to monitor one patient may not be the same as those needed to monitor another patient. Furthermore, of any test panels that might be devised for patient monitoring and management, the SMA 12 is undoubtedly the worst, as the machine inflexibly performs the same 12 tests each time, no matter what the clinical indications may be.

New Technology: The newest generation of Clinical Chemistry lab instrumentation, such as has been recently introduced at BMC, is computer directed, random access technology which allows the operator to select what test or tests should be run on a particular patient sample. The new instrument is also technically much simpler to operate and troubleshoot than the SMA 12. These features not only allow the physician to order customized groups of lab tests for each patients, but they also allow around-the-clock availability of tests as opposed to only day shift operation by the more highly trained SMA 12 specialists.

Test Charges and Cost Accountants: Having decided that SMA 12 screens and other test panels were not appropriate, it became a relatively simple matter to devise the charge per test on the new BMC instrument system. Our task was to make the new system "revenue neutral" under the tenets of the Massachusetts Cost Control Law, Chapter 372. Looking at the SMA 12 panel, I guessed that some physicians had ordered it when they knew they required only two or three values, while up to eight or nine results might be required when it was used as an admission profile or to monitor complex clinical situations, such as cardiac surgical patients or ICU patients. An average number of tests per sample to replace SMA 12 requests was determined to be about 4.5. With this information, our charge per test was set, subject of course, to adjustment as experience was gained.

The new system has been operational at BMC for about three months. Clinicians' feedback to me is often similar to Dr. Higby's comments, but almost all also say that both the scientific and cost advantages of the new system outweigh their feeling of loss of an old friend. Further, they emphasize that, in this new era of prospective payments and DRG's, physicians must be leaders rather than followers in adjusting to these new realities.

To date, an average of approximately three tests is done for each SMA 12 previously ordered, so patients are realizing cost savings. I appreciate clinicians' difficulty to adjust to rapid change after a whole generation of use of the SMA 12 instrument and I intend to make no further changes until an adequate period of adjustment has been completed. At that time, price adjustments and/or offering a limited number of small test panels, developed by perusal of actual ordering patterns, may be proposed.

Like Dr. Higby, I have lost an old friend. Successful implementation of the new system, however, is rapidly making that feeling a distant memory. ■

Jerald M. Rosenbaum, M.D., Pathologist
Director, Clinical Chemistry Laboratory
Baystate Medical Center

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# Executive Committee

A meeting of the Executive Committee of the Hampden District Medical Society was held on Monday, September 16, 1985 at the Society's office. The meeting was called to order at 7:30 p.m. by Dr. Asinas, President.

Present were: Drs. Asinas, Coe, O'Neill, Remsberg, Ryan, Slachta, Smith, Stoler and Walthall, Mrs. Virginia Walthall, Auxiliary President and Mrs. Nystrom. Invited guest were Maureen Skipper, Executive Director of Springfield Visiting Nurses Association, with Dianne Doherty and Marsha Tzoumas of Doherty/Tzoumas Marketing.

The minutes of the June 24, 1985 meeting were approved.

Ms. Skipper explained that the VNA is 72 years old and is facing a great deal of competition. The parent corporation is the VNA Foundation of Pioneer Valley. The VNA is having a marketing study done by Doherty/Tzoumas. A questionnaire was distributed to the Executive Committee and members were asked to fill it out. The three issues most important to this study are: 1. What are your criteria for home health services; 2. How do you see the strengths of the VNA; 3. Suggestions as to how the VNA could reach referral groups. Suggestion was made that the VNA reach the key person in each doctor's office as usually there is one person who decides which agency to use. Questionnaires were returned to Ms. Skipper and she thanked the Executive Committee for their assistance in this portion of the VNA Survey.

OLD:

1. OFF SHORE MALPRACTICE INSURANCE COMPANY:
   Dr. Smith reported that Mr. Donald MacMeekin had drawn up two surveys which were unacceptable. Dr. Smith terminated the project because the market is so uncertain and asked Mr. MacMeekin to submit a bill for his services
2. MEDICAL ETHICS SEMINAR:
   Mrs. Nystrom reported that 145 persons had attended the September 11th Seminar. Educational credits were awarded to physicians, RN's, LPN's, and social workers. Evaluation forms were very positive. The Medico-Religious Committee hopes to make this ethics seminar an annual event. A letter of appreciation for a job well done will be sent to Dr. Fitzpatrick.
3. NOVEMBER 1ST DANCE:
   Mrs. Walthall showed the dance invitation to the Committee and reported they would be mailed in October to over 600 physicians. A half page ad will be in the next Hippocrat. The Auxiliary has been working very hard and a good turn out is expected. Non-physicians will be welcomed.

NEW:

1. WESTFIELD CITIZENS FOR FLUORIDATION:
   After discussion, a motion was made and carried to send a letter endorsing the principle of Fluoridation to the Westfield Citizens For Fluoridation. Their request for $2,000 in financial support had been sent to MMS. The request was approved by the MMS Executive Board and will be brought before the MMS Council on October 9th.
2. PROPOSED RESOLUTION ON CONSULTING PHYSICIAN ETHICS FROM DR. SIRAGUSA:
   After discussion, motion was made and carried unanimously to have Dr. Asinas call MMS President, Dr. Rockett and get her approval to have this brought before the MMS Ethics & Discipline Committee because it was felt the proposal should be better defined.
3. ANNUAL MEETING SPEAKER:
   Dr. Asinas said Governor Michael Dukakis will be asked to speak. If the Governor accepts it was suggested that a half-hour leadership cocktail party might be considered. Dr. Slachta announced he would hold a cocktail party in his home on November 8th from 6 to 8 p.m. for Senator John Kerry and asked the Committee members to attend.
4. PUBLIC HEALTH COMMITTEE REQUEST TO PURCHASE EDUCATIONAL TAPES:
   After discussion, motion was made and carried to purchase the tapes on Nuclear War for use in the schools. However, all the tapes must be reviewed and approved by a representative of the Public Health Committee and a member of the Springfield School Committee prior to purchase.
5. MEMORY EXPANSION FOR COMPUTER:
   Dr. Pelletier requested purchasing an addi-

*Continued on next page*

# Executive Committee

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tional 256 K memory for the computer at a cost of $360.80. His request was moved and carried unanimously and the Committee felt Dr. Pellitier should be allowed to purchase more memory than the 256 K requested if he feels it is needed.

6. PUBLIC HEARING ON MALPRACTICE:
Dr. Smith received a phone call from Senator Melconian that there would be a Public Hearing on Malpractice on October 3rd at 2 p.m. in Springfield. It was decided that Doctors Slachta and Smith would co-chair the effort to get a large number of physicians to attend. They will also set up a list of speakers to cover physicians in all areas of practice speaking on how the crisis is affecting them personally. A mailing announcing the hearing will be mailed this week to the membership.

LETTERS:
The following letters were accepted as informational:

1. A letter from Dr. Pacosa requesting support of Dr. Harrison as Chairman of MMS's Tax Supported Medical Care Committee.
2. Dr. Rockett's letter to John Larkin Thompson of Blue Shield in regards notice of liens.
3. Letters sent by Dr. Samuel Hellerman in regards the malpractice crisis.

The next meeting of the Executive Committee will be Monday, October 21, 1985 at 7:30 p.m.

There being no further business, the meeting was adjourned at 9:10 p.m. ■

Respectfully submitted,

William W. Walthall, Jr., M.D.
Secretary


## *CHALLENGE*

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